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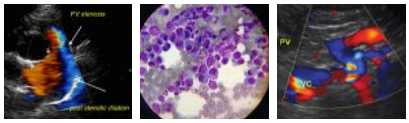

SonoPath
Clinical Sonography & Telecytology
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DATE

3/6/22

PATIENT

Cooper Slowikowski

SPECIES

Feline

BREED

Tonkinese

SEX

Neutered Male

AGE

2019

WEIGHT

10 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Ruby

INVOICE

10509

PRESENTING CLINICAL SIGNS

Presenting Complaint: Referral for Continued Care. Icterus (Jaundice).

History: Date: 03-04-2022 Notes: Hx of allergy to chicken. Eats special diet. Had been eating ATO, no BM's for a couple of days. Today vomiting. Seen by RDVM, elevated LE and increased stool ATRDVM. They gave enema and transfer to AEH for continued care and +/- US Had been tested for FeLV/FIV prior to adoption, negative owner email record form shelter

Assessment: Vomiting, Diarrhea, elevated LE, Icterus .

Current Medications: ampicillin/sublactam, maropitant, and denamarin.

Lab Results: Attached. RDVM (3/4/2022): ALT = 492; T.bil = 3.8 and ALP = 156 3/5/2022: ALT = 707, T.bil = 3.8 and ALP = 138
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV sedation.
Stat Report: Not requested.

Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small to moderate amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (4.00 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Trace pyelectasia is present (0.17 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Trace pyelectasia is present (0.18 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.31 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.49 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.62 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver
The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and homogenous in appearance. No distinct focal lesions are observed. There is a subtle increase in portal markings. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is mildly thickened (up to 0.24 cm), and hyperechoic. Luminal contents are mostly anechoic. The cystic and common bile ducts are tortuous/slightly dilated (up to 0.21 cm). The walls are thickened. The common bile duct can be followed to the level of the duodenal papilla. There is no evidence of an intraluminal obstruction. The duodenal papilla is normal in size (0.37 cm in width).

Gastrointestinal
The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal to mildly thickened (up to 0.31 cm), with a normal layering pattern. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in most segments. A line of mucosal fibrosis is seen in some regions. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas
The pancreas is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen
There is no evidence of free fluid. A few prominent lymph nodes are observed in the right cranial quadrant and midabdominal region, the largest measuring 1.15 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

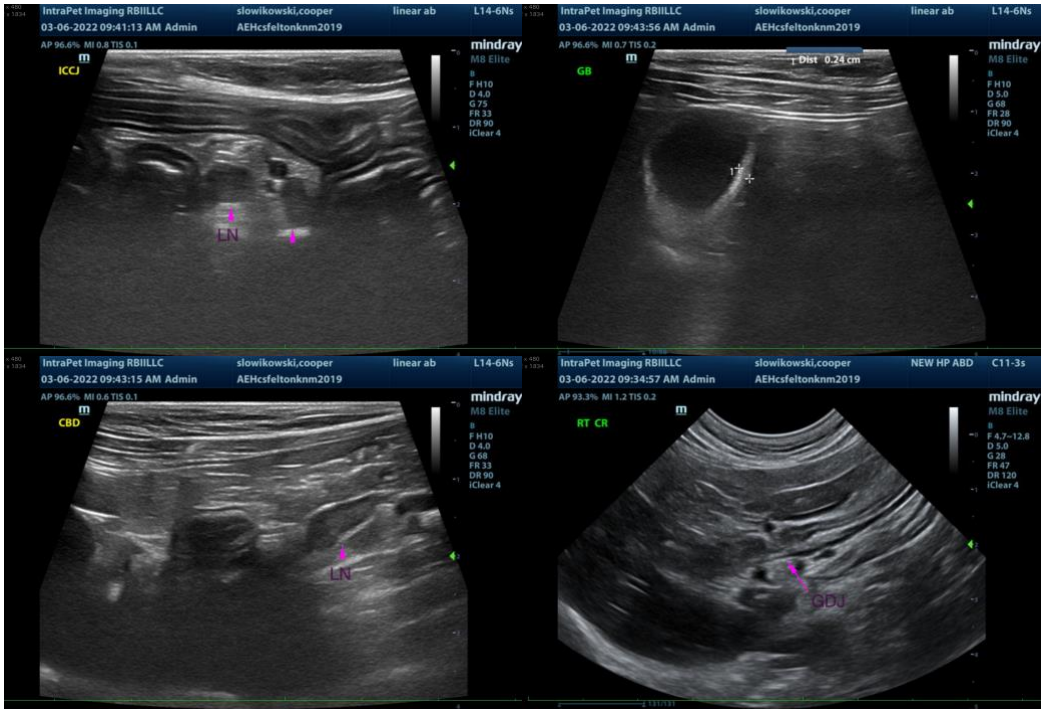
- The hepatic changes are most consistent with an inflammatory process (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis). However, other microscopic hepatopathies (i.e., emerging hepatic lipidosis, infiltrative neoplasia), cannot be excluded.
- The gall bladder and common bile duct wall changes are most consistent with cholecystitis and cholangitis, respectively.
- Bowel pattern consistent with inflammatory bowel disease with some potential for emerging lymphoma
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

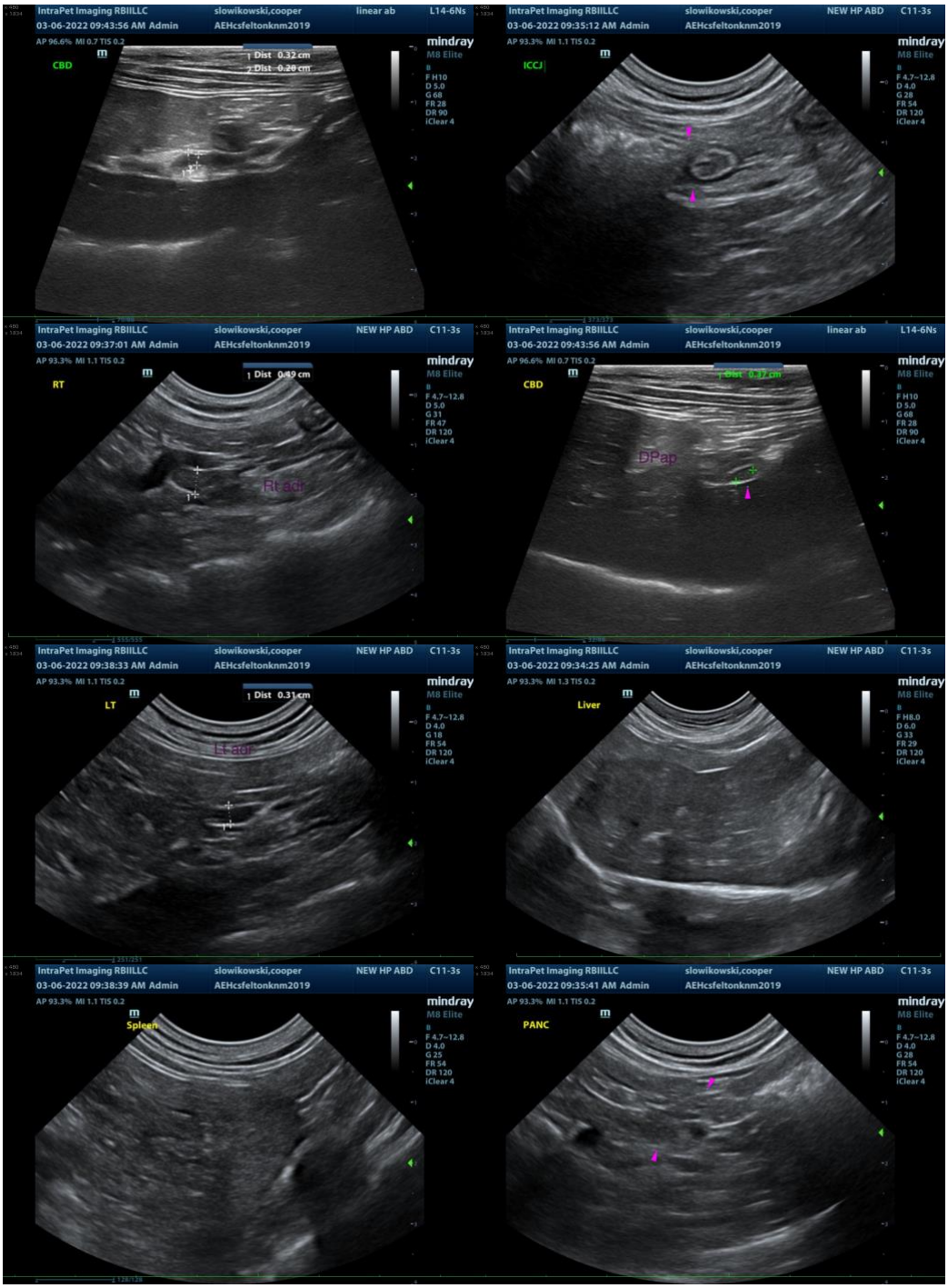
Secondary Findings

- Bilateral chronic renal changes with trace pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Continued supportive care for cholangiohepatitis/cholecystitis/cholangitis is recommended (i.e., broad-spectrum antibiotics, hepatic antioxidants, fluid therapy).
- If liver values and the patient's clinical status do not begin to improve within 3-5 days of initiating therapy, hepatic tissue sampling (i.e., fine-needle aspirate or surgical biopsy) may be warranted. If surgical biopsies are pursued, aerobic and anaerobic bile cultures are also recommended, along with gastrointestinal biopsies. If the patient's caloric intake is inadequate, consider placement of a temporary feeding tube (i.e., esophagostomy) to help prevent/treat hepatic lipidosis.
- A malabsorption panel including serum cobalamin, folate, TLI and PLI is also recommended.
- Given the history of vomiting, three-view thoracic radiographs should be considered to assess for occult aspiration pneumonia.

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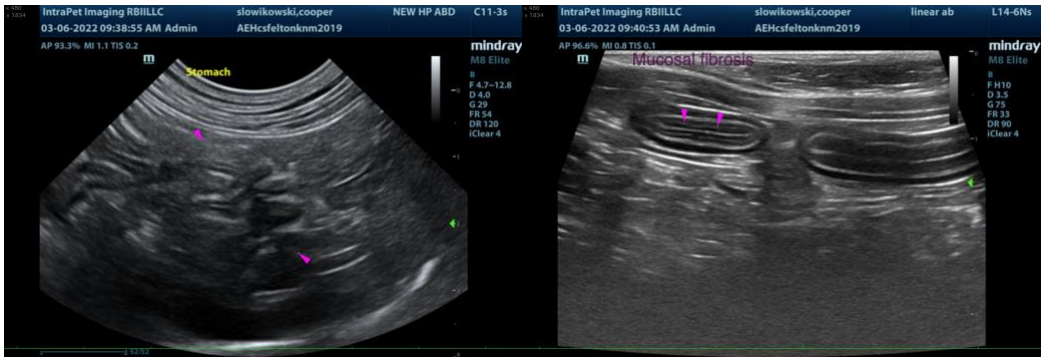

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.